HOLISTIC
HEALTH CLINIC
NATUROPATHIC PHYSICIANS

Patient Agreement for Plan Services

This Patient Agreement for Plan Services *(the "Agreement")* describes the terms and conditions under which you, the undersigned patient, may receive care at Holistic Health Clinic *("Holistic Health").*

This Agreement starts on the day both you and an authorized representative of Holistic Health Clinic have signed it *(the "Effective Date")* and continues until terminated by either you or Holistic Health Clinic, as described below. By signing this Agreement, you agree to the terms and conditions of this Agreement and you agree that the information that you provide herein is accurate. You are responsible for updating any information provided in this Agreement within 30 days of any changes.

1. Service Options. Holistic Health Clinic offers the following service plan options *("Plans")* for patients to receive care beyond what is traditionally covered by health insurance *(collectively referred to as the "Services")*. You may select one of the following three Plans by indicating your selection at the bottom of this Agreement where indicated.

a. **Premium Access**. This Plan is available on a monthly basis and includes the following Services:
- 45-minute clinic visits;
- Extensive portal and phone access;
- Multiple doctors collaborating on your care;
- Dedicated staff to work with insurance companies on your behalf, should billing issues arise;
- Priority scheduling so that you can schedule an appointment within 48 hours of contacting Holistic Health Clinic, subject to availability;
- Cancellation fees waived up to twice per twelve month period;
- Free or discounted special offers;
- Free shipping on supplement orders of $50;
- Free body compositions quarterly;
- Free vitamin B injections monthly.

b. **Enhanced Access**. This Plan is available on a monthly basis and includes the following Services:
- 45-minute clinic visits;
- Limited portal and phone access;
- Multiple doctors collaborating on your care;
- Dedicated staff to work with insurance companies on your behalf, should billing issues arise;
- Free body composition measurements twice per year;
- Free vitamin B injections twice per year.

c. **Pay As You Go**. This Plan provides the option to pay for Services as needed. You will have access to your provider for up to two weeks after your visit to resolve any unexpected issues that may arise with your treatment plan. The following Services are included each time you select the Pay As You Go option:
- 45-minute clinic visits;
- Limited portal and phone access for two weeks after each visit to resolve any unexpected issues with your current treatment plan;
- Multiple doctors collaborating on your care; and

- Dedicated staff to work with insurance companies on your behalf, should billing issues arise.

2. Medical Services Excluded. The Plans do not include any medical services that you may receive from Holistic Health Clinic or its staff, including your physician (the "Excluded Services"). In particular, all medical services that are considered "covered services" by your insurer (including Medicare, if you are a Medicare beneficiary) are Excluded Services. Examples of Excluded Services include, but are not limited to office visits, urgent care appointments, and telephone and telehealth consultations that are covered services. Excluded Services will be charged separately either through your insurance or to you, if you have elected to self-pay for your care.

3. Self-Pay Patients. If you do not have health insurance or are otherwise electing to self-pay for care at Holistic Health, you can continue to receive care by paying the rates described in the Cash Pay Fee Schedule, which is available on Holistic Health Clinic's website at: https://theholistichealthclinic.com/appointmentsforms/. To receive any of the additional Services described above in Section 1, you can elect to participate in one of the Plans and pay for Premium Access or Enhanced Access.

4. Plan Fees. The cost of participating in any of the Plans ("Plan Fees") is set on an annual basis and is payable monthly, due on the first day of each month. The Plan Fees are described below for each Plan level. Holistic Health Clinic will notify you at least 60 days prior to any changes in the Plan Fees.

Plan	**Plan Fees**
Premium Access	Ages 26 & up: $99/month Ages 18-25: $89/month Ages 0-18: $79/month
Enhanced Access	Ages 26 & up: $39/month Ages 18-25: $29/month Ages 0-18: $19/month
Pay As You Go	$49 per visit

5. Termination. You may terminate this Agreement at any time by giving Holistic Health Clinic written notice of termination as provided in Section 8 below. Holistic Health Clinic may terminate this Agreement at any time by giving you at least 30 days' written notice. Your final Plan Fees billing will occur on the termination date. Unless the termination date is the last day of a month, your final Plan Fees payment will be a prorated portion of the current monthly Plan Fees amount as of the termination date.

6. Co-Payments, Co-Insurance and Deductibles. The Plan Fees do not affect the co-payments, co-insurance or deductibles that you are required to pay pursuant to the terms of your insurance coverage, and because the Services are not considered covered services by your insurer, the Plan Fees will not count toward your deductible or any out-of-pocket maximum amount under your insurance coverage. You will continue to be financially responsible for any co-payments, coinsurance or deductible amounts required by your insurer.

7. Entire Agreement. By signing below, you agree to the terms of this Agreement. Holistic Health Clinic makes no promises or representations except as set forth herein.

8. Notices. Any notices required or permitted to be sent under this Agreement shall be in writing and sent via U.S. mail to the addresses set forth in this Agreement. Any change in address shall be communicated in accordance with the provisions of this section. Notices to Holistic Health Clinic shall be sent to:

1530 S. Union Avenue Suite 4

Tacoma, WA 98405

9. Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the state of Washington.

I, _____ [insert full name of patient or legal representative], elect to participate in the following Plan and hereby agree to the terms and conditions of this Agreement [insert initial next to your Plan selection]:

____ Premium Access

____ Enhanced Access

____ Pay As You Go

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement effective as of the Effective Date.

Patient	**Holistic Health Clinic**
Signed: _____	Signed: _____
Name: _____	Name: _____
Date: _____	Date: _____

PATIENT INFORMATION

Mailing Address _____

City _____ State _____ Zip _____

Phone: Home (_____)_____ Office (____)_____ Cell (____)_____

Date of Birth _____/_____/_____